Signature MEDICAL SPA
A DIVISION OF ALBEMARLE DERMATOLOGY ASSOCIATES

NEUROMODULATOR CONSENT FORM

BOTOX® Cosmetic, Xeomin, Daxxify and/ Dysport

PLEASE READ CAREFULLY BEFORE SIGNING

This document describes 1. the nature of your condition, 2. the nature of proposed treatment, 3. the risks of the proposed treatment, and 4. reasonable therapeutic alternatives and risks associated with such alternatives.

You have the right to be informed about your condition and the recommended medical procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved.

You are being asked to sign a confirmation that we have discussed all of these matters. We wish to inform you as completely as possible. Ask about anything you do not understand, and we will be pleased to explain it.

Treatment: *BOTOX® Cosmetic, Xeomin®, Daxxify and/or Dysport®* injection for rhytids (wrinkles)

Purpose: Reduction in facial wrinkles

Condition: Facial muscle over activity; aging.

Possible side effects of treatment: All medical treatment involves risks. The following risks are associated with the treatment described above on this consent form. *Please initial each section after reading.*

- Eyebrow ptosis (eyebrow droop)
- Lid ptosis (eyelid droop)
- Diplopia (double vision)
- Incomplete wrinkle treatment
- Overcorrection
- Headache
- Ecchymosis (bruising)

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Rare complications include: allergy to botulinum toxin, penetration of the globe, peribulbar hemorrhage, worsening of dry eye symptoms, ectropion, tearing, inadvertent muscular weakness.

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Contraindications: Neuromodulators should not be used if you are pregnant, breastfeeding, or have a disorder of the neuromuscular junction, such as myasthenia gravis or myopathy. Clients may elect not to have the procedure, or have alternative treatments for wrinkle improvement. Dysport should not be used in the case of allergy to cow's milk protein.

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ACKNOWLEDGEMENT, AUTHORIZATION, AND CONSENT

No Guarantee: All information given me, and in particular, all estimates made as to the likelihood of occurrence of risks of this or alternate procedure, or as to the prospects of success, are made in the best professional judgment of my physician or nurse. The possibility and nature of complications cannot always be accurately anticipated and, therefore, there is and can be no guarantee, either expressed or implied, as to the success or other results of the medical treatment. *Please initial each section after reading.*

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Additional Information: Nothing has been said to me, no information has been given to me, and I have not relied upon any information that is inconsistent with the information set forth in this document.

Distant Spread of Toxin Effect: The effects of botulinum toxins may spread from the area of injection. Symptoms of a spread have been reported hours to weeks after injection. Rare swallowing and breathing difficulties can be life threatening. The reports of these incidents were following medical use of botulinum in large amounts. Immediate medical attention may be required in cases of respiratory, speech or swallowing difficulties. No dangerous side effects have been reported after cosmetic usage.

Particular Concerns: I have had an opportunity to ask, and have asked, any questions I may have about information in this document and any other questions I have about the proposed treatment, and all such questions were answered in a satisfactory manner.

I have been advised to remain upright for 1 hour after the treatment- no bending over, lying down, or exercise. Do not massage or touch injected area for 1 hour. Avoid tight fitting hats, headbands, goggles or bike helmets for 1 hour after your procedure.

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CONSENT

I hereby authorize and direct the physician or nurse designated below, together with associates and assistants of her choice, to administer or perform the medical treatment described on this form.

I have read and understand all information set forth in this document, including all material risks indicated by my physician or nurse, and all applicable blanks were filled prior to my signing.

This authorization for and consent to medical treatment is and shall remain valid until revoked by me in writing.

I acknowledge that I have had the opportunity to ask any question about the contemplated treatment described in this consent form, including risks and alternatives, and acknowledge that my questions have been answered to my satisfaction.

Client Signature _____ Date _____

Client Signature _____ Date _____

Provider Certification: I hereby certify that I have provided and explained the information set forth herein, provided the client with an opportunity to ask questions, and answered any questions to the best of my knowledge and ability.

Provider Name and Signature _____ Date _____

Provider Name and Signature _____ Date _____